

# MONTANA BOARD OF MEDICAL EXAMINERS

## TEMPORARY EMERGENCY / DISASTER EXEMPTION FOR EMERGENCY MEDICAL TECHNICIANS NOT LICENSED IN MONTANA PO BOX 200513, 301 S PARK, HELENA, MT 59620-0513 PHONE: (406) 841-2364 FAX (406) 841-2305

This form is designed to provide a temporary exemption to the requirement for Montana licensure under ARM 24.156.2771(5) of Montana Codes Annotated.

The Board of Medical Examiners is granting an exemption from Montana state licensure for the purposes of providing necessary flexibility for Federal/State Emergency/Disaster Managed Incidents and Managing Agency.

1) The exemption authorizes a currently licensed EMT, in good standing from another state to function at a "basic life support" level even if the EMT is licensed at a higher level in another state, unless the individual is licensed at an EMT-I or EMT-P level, **and** the federally managed incident has medical control provided by a Montana licensed physician, **and** the physician authorizes the individual to function beyond the basic level; **and**

2) The exemption is temporary and limits the EMT's practice to the duration of the Federal/State Managed Incident and will expire upon conclusion of the Federal/State contract or assignment; **and**

4) The exemption limits the EMT's practice to the geographic area assigned and designated by the Federal/State Managed Incident; **and**

5) The EMT **must provide proof** of a current unrestricted licensure in another state **with this completed form**.

**Please PRINT the following information and return to the  
Montana Board of Medical Examiners with PROOF OF CERTIFICATION AND OR LICENSURE:**

Full Name: \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_  
(PO Box or Street) (City) (State) (Zip)

**Current State Certification / Licensure information:** Certification Level: ☐FR ☐B ☐I ☐P

State: \_\_\_\_\_ Certification/License #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

I wish to function at the ☐I or ☐P level **and** I have spoken with Dr. Jim Upchurch, IMS Medical Director.

### INCIDENT

Assignment: \_\_\_\_\_ (name of incident) Location of Incident: \_\_\_\_\_

Unit Medical Leader: \_\_\_\_\_

### AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my form for temporary exemption to be true and complete to the best of my knowledge. In signing this form, I affirm that I have read and am familiar with the applicable licensure laws of the State of Montana including the Montana Prehospital Treatment Protocols for Basic life support approved by the Board. I accept and will abide by the Montana Board of Medical Examiners requirements and conditions under which this exemption is granted and that I will not practice above the Basic Life Support Level regardless of my current certification/license level.

Legal Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**Fax to: (406) 841-2305, then MAILORIGINAL to: Montana Board of Medical Examiners  
301 S Park, Room 430  
PO Box 200513  
Helena MT 59620-0513**